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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **RIQUEZA TINIO UMALI** **228 Gable Court** **Beaumont, CA 92223** **Registered Nurse License No. 646658** Respondent.	Case No. 2013-124 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about October 20, 2004, the Board of Registered Nursing issued Registered Nurse License Number 646658 to Riqueza Tinio Umali (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2014, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

6. Section 2811(b) of the Code provides, in pertinent part, that the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

7. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
>
> . . . .

REGULATORY PROVISIONS

8. Title 16, California Code of Regulations, section 1442, provides:

> As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

COST RECOVERY

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTUAL ALLEGATIONS

10. Respondent was employed as a registered nurse at San Gorgonio Memorial Hospital (SGMH) from March 27, 2003 to July 15, 2004, and then was rehired in March, 2005. Respondent was the Charge Nurse at SGMH in the Medical/Surgical Telemetry Unit on the night shifts from September 17, 2008 at approximately 19:00 hours to September 18, 2008 at 07:00 hours, and September 18, 2008 at approximately 19:00 hours to September 19, 2008 at 07:00 hours. As Charge Nurse, Respondent was responsible for overseeing the registered nurses in her assigned unit, including making frequent rounds to ensure patient care and safety, being aware of patient incidents and/or changes in condition and reporting those occurrences to other staff, assisting and communicating with the nursing staff, and ensuring physician orders received during the shift were executed in a timely manner.

11. Patient A was admitted to the Medical/Surgical Telemetry Unit at SGMH during the day shift (0600 hours to 1830 hours) on September 17, 2008 at 17:25 hours. Patient A's admitting diagnoses included newly-identified weakness/paralysis, slurred speech, cerebrovascular accident (stroke) and hypertension (high blood pressure). Patient A's assessment report reflected that Patient A was to be on bed-rest, required assistance from the nurses and had a history of falls. The initial care plan contained a note on September 17, 2008 at 17:36 hours stating that Patient A was at risk for falls. The Morse Fall Scale[1] is an assessment tool used by S.G.M.H. to evaluate a patient's risk for falls. Patient A's score upon admission was documented

[1] A Morse Fall Scale score of 0-24 means that there is a low risk of fall, 24-50 means that there is a medium risk of fall, and 51 and above means that there is a high risk of fall. If a patient's fall risk is determined to be high, the nursing care plan is changed to reduce a patient's risk of falling.

as 45 (medium risk of fall) based on a history of a fall at home 1-2 weeks prior to admission. In addition, Patient A had lower extremity weakness, a weak gait and an IV in place.

12. During the night shift, at approximately 5:00 hours on September 18, 2008, Patient A fell in the unit. An LVN was assigned to Patient A at the time of the fall and was aware of the fall. The LVN wrote in a late entry nursing note that she notified the assigned registered nurse, RN Ruth, of Patient A's fall. The LVN contacted the physician assistant, who assessed Patient A after the fall, and documented the assessment in Patient A's medical record in the Interdisciplinary Progress Notes. Respondent was not aware that the physician assistant had done an assessment.

13. Respondent and RN Ruth did not report Patient A's fall to the oncoming day shift beginning at approximately 6:00 hours on September 18, 2008. Respondent denied having knowledge of Patient A's fall. As a result, Patient A's plan of care was not modified, the fall risk score was not increased and the monitoring of Patient A was not increased to prevent a subsequent fall.

14. There was no report of any unusual behavior by Patient A during the day shift on September 18, 2008 from 6:00 hours to 18:30 hours. At the change of shift at approximately 18:00 hours, the day shift nursing staff gave a report to the on-coming night nursing staff assigned to Patient A, including RN Rebecca.

15. During the night shift on September 18, 2008, Patient A was seen out of bed on at least three different occasions. RN Rebecca notified Respondent that the patient was seen out of bed. RN Rebecca requested a sitter to monitor Patient A, but was informed by Respondent that a sitter was not available. RN Rebecca obtained an order for a safety belt, soft wrist restraints, and Haldol at 21:15 hours. RN Rebecca asked Respondent for the physical restraints. RN Rebecca, who was a registry nurse, was unaware of where the restraints were located and believed that Respondent would obtain the restraints which were kept in the House Supervisor's office.[2]

[2] Staff were able to obtain the restraints with no checkout procedure.

Haldol was not administered to Patient A because the patient was asleep. The restraints were not applied to Patient A prior to 21:55 hours.

16. On September 18, 2008, at approximately 21:55 hours, Patient A was found lying face down outside his assigned room, the result of a second fall. Patient A sustained serious physical and neurological injuries causing deterioration in the patient's physical condition. A CT scan of Patient A's brain after the fall confirmed subarachnoid hemorrhage.[3]

17. Patient A was transferred to facility B on September 19, 2008 at 9:10 hours due to complications from the second fall. Patient A died on September 23, 2008 at 19:06 hours with the cause of death listed as subarachnoid hemorrhage and blunt force trauma as the result of an accident.

CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Gross Negligence)

18. Respondent is subject to disciplinary action for unprofessional conduct under section 2761(a)(1) of the Code in that during her assigned shifts as Charge Nurse at SGMH, Respondent was grossly negligent by failing to provide care which she knew or should have known jeopardized the patient's life, as is set forth in paragraphs 10 through 17 above, as follows:

a. Respondent failed to communicate with the nursing staff or review the physician's assessment, and as a result was unaware of Patient A's fall at 5:00 hours on September 18, 2008, which resulted in Patient A's plan of care not being modified.

b. Respondent failed to supervise timely execution of the physician's order for Patient A to receive physical and chemical restraints, and failed to provide assistance in obtaining the physical restraint devices, resulting in Patient A's second fall at 21:55 hours on September 18, 2008.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

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[3] A subarachnoid hemorrhage is a bleeding in the brain.

1. Revoking or suspending Registered Nurse License Number 646658, issued to Riqueza Tinio Umali;

2. Ordering Riqueza Tinio Umali to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: August 13, 2012

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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